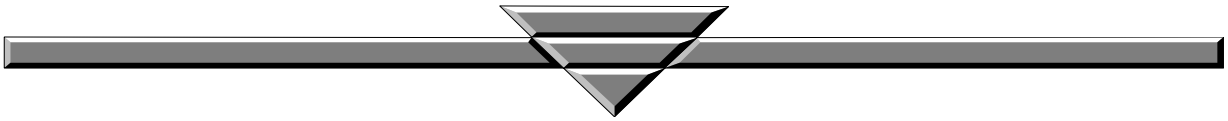


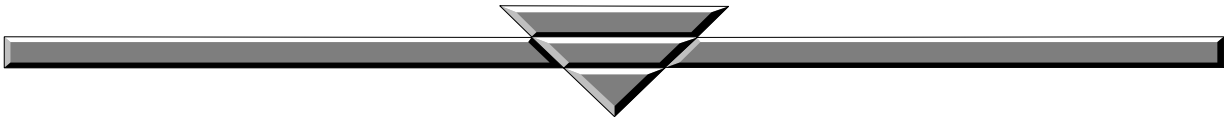
City of St Paul

Cafeteria Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 1989

(Amended and Restated Effective January 1, 2004)



City of St Paul

Cafeteria Plan

SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to explain the City of St Paul Cafeteria Plan in a manner that you can easily understand. If you have any questions after reading this Summary Plan Description, please call the Plan Administrator at 651-266-8880.

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GENERAL INFORMATION

WHAT IS THE PURPOSE OF THIS PLAN?

City of St Paul has established this Plan to make available to Eligible Employees on a pre-tax basis different combinations of health care benefits, dental care benefits, health care reimbursement benefits, dependent care reimbursement benefits, life insurance benefits, and direct (taxable) compensation.

WHAT ARE SOME DEFINITIONS?

Here are some definitions that will help you better understand this summary of the Plan:

a) *AFFILIATE* - means an entity (other than the Company) that is part of a group of entities that includes the Employer and constitutes (i) a controlled group of corporations (as defined in Section 414(b) of the Code), (ii) a group of trades or businesses, whether or not incorporated, under common control (as defined in Section 414(c) of the Code), or (iii) an affiliated service group (within the meaning of Section 414(m) of the Code).

b) *EMPLOYER* - City of St Paul.

c) *DEPENDENT* – A person whom you can claim as a dependent on your federal income tax return. In general, a person will qualify as your dependent for a year if you provide more than one-half (1/2) of his or her support during the year and certain other tests are met.

   Your dependents will usually include your children who were under the age of nineteen (19) at the end of the year or who were full-time students.

   Your dependents may also include other persons who are either related to you by blood or marriage or lived in your home as a member of your household during the entire year if they had less than $2,700 of gross income during the year (excluding nontaxable amounts such as social security or welfare benefits). The instructions to your federal income tax return discuss in some detail who qualifies as your Dependent.

d) *EFFECTIVE DATE* – The Effective Date this plan became effective was January 1, 1989. The Effective Date of this Amendment and Restatement is January 1, 2004.

e) *ELIGIBLE EMPLOYEE* – means an Employee of the Employer or an affiliated entity who has met the eligibility requirements of the Employer sponsored health plan may participate in this Plan on the first of the month following thirty days of employment.

f) *PERIOD OF COVERAGE* – For dependent care benefits the Period of Coverage is generally the same as the Plan Year. However, if a person becomes a participant after a Plan Year has started, that participant's Period of Coverage begins on his or her first day of participation and continues for the remainder of the Plan Year.

For example, if a person becomes a participant on October 1, 2004, that person's Period of Coverage for Dependent Care reimbursement benefits for that Plan Year is October 1, 2004 through December 31, 2004.

For all other benefits, including health care reimbursement benefits, the Period of Coverage will generally be the same as for dependent care reimbursement benefits. However, if you are no longer on the Employer's payroll and you stop paying for these other benefits, your Period of Coverage will end early.

For example, if you terminate employment or take an unpaid leave of absence, your Period of Coverage will cease as of the end of the last month for which you pay for coverage (SEE CONTINUATION COVERAGE).
If you take a "family or medical leave," you may be able to reinstate your health/dental/life coverage and health care reimbursement benefits. This would affect your Period of Coverage for health care reimbursement benefits (SEE LEAVES OF ABSENCES AND FAMILY OR MEDICAL LEAVES)

g) *PLAN* – This City of St Paul Cafeteria Plan, as may be amended from time to time.

h) *PLAN YEAR* – The Plan Year is the calendar year.

i) *QUALIFYING INDIVIDUAL* – A participant's dependent who is under the age of thirteen (13), and a participant's spouse or dependent of any age who is physically or mentally incapable of caring for him or herself.

j) *STATUS CHANGE* – Changes in family status for which a benefit election change may be permitted includes change in legal marital status, change in the number of tax dependents, employment status change for you, your spouse or dependent, a dependent satisfying or ceasing to satisfy eligibility requirements, a residence change by you, your spouse or dependent, a change in the cost or coverage for dependent care, a change in coverage due to your spouse or dependent's open enrollment or the beginning or ending of adoption proceedings for adoption benefits. Please note: the event must affect eligibility for benefits and the requested change to your election must be consistent with the event.

WHAT TYPE OF PLAN IS THIS?

This is a flexible benefit plan that permits participants to choose among more than one benefit. It is classified as a "cafeteria plan" for federal income tax purposes.

ELIGIBILITY

WHEN CAN I PARTICIPATE IN THE PLAN?

A newly Eligible Employee may elect to become a participant in the Plan on the date after he or she first becomes an Eligible Employee and satisfies the participation conditions. Eligible Employees who do not become participants when they first become eligible may become participants on the first day of a Plan Year, or under certain circumstances when a status change occurs.

WHAT ARE THE CONDITIONS OF PARTICIPATION?

As a condition to participate in the Plan and to receive reimbursement benefits under this Plan, you must:

1. Execute and deliver to the Employer prior to becoming eligible to participate in the Plan an application to participate in the Plan and a benefit election form;

2. Authorize Pre-tax Contributions in the required amount;

3. Observe all Plan rules and regulations;

4. Agree to inquiries by the Employer with respect to any physician, hospital, or other provider of health care or other services covered by this Plan; and

5. Submit to the Employer all reports, bills, and other information that the Employer may reasonably require.

If you do not make a benefit election within the time period required by the Plan, you will not be eligible to pay for your benefits on a pre-tax basis.

HOW THE PLAN WORKS

HOW DO I PAY FOR BENEFITS?

Benefits are paid for by you using your Pre-tax Contributions. Pre-tax Contributions are discussed below.

WHAT ARE PRE-TAX CONTRIBUTIONS?

Pre-tax Contributions are the amounts by which you reduce your regular gross (before tax) wages or salary in exchange for the Employer's contribution of equal amounts to the Plan. You will authorize Pre-tax Contributions by signing the application to participate. Any required employee contributions for benefit coverages will be automatically withheld on a pre-tax basis.

WHAT BENEFITS ARE PROVIDED UNDER THE PLAN?

The types of benefits available to you under the Plan allow you to improve on those benefits based on your individual needs. The benefits offered under the Plan are described below. If you do not elect to participate in these pre-tax benefits, you will receive your regular taxable wages.

1. Health Coverage. Payment of the employee cost of employee or family coverage under the City of St Paul Health Plan. This health plan is described in the City of St Paul Health Plan Summary Plan Description.

2. Life Insurance Coverage. Payment of the employee cost of up to $50,000 of coverage under the City of St Paul Life Insurance Plan. This life insurance plan is described in the City of St Paul Life Insurance Plan Summary Plan Description.

3. Dental Coverage. Payment of the employee cost for employee or family coverage under the City of St Paul Dental Plan. This dental coverage plan is described in the City of St Paul Dental Plan Summary Plan Description.

4. Health Care Reimbursement Expenses. If you elect health care reimbursement coverage, you can use your available Pre-tax Contributions to be reimbursed for health care expenses incurred by you, your spouse or any of your dependents during the Period of Coverage for a Plan Year that are related to the diagnosis, treatment, or prevention of disease or for sickness and injury.

   Premiums for insurance coverages and similar expenses (e.g., payments for a spouse's HMO coverage) are **not** reimbursable. If you elect to receive health care reimbursement coverage, within the Plan's limits you will elect your level of coverage for the Plan Year. The maximum level of coverage is $4,000 per Plan Year.

   IRS Publication 502, which you may obtain from the Internal Revenue Service, describes tax-deductible health care expenses, which are very similar to the expenses eligible for reimbursement. There are, however, some important differences to note which you will not find in that publication. The cost of over-the-counter drugs may be reimbursed under the Plan if they have been purchased for the diagnosis, treatment, or prevention of disease or for treatment of sickness or injury, regardless of whether they are deductible for federal income tax purposes and regardless of whether or not they have been prescribed by a physician. Also note that any expense covered by an insurance policy or which will be reimbursed from any other source is ineligible for reimbursement. In addition, expenses for cosmetic procedures that are not medically necessary are not eligible for reimbursement.

   The following list gives examples of the types of health care expenses covered:

   Surgical services
   Hospital services
   Laboratory services
   Prescription medicine and drugs
   Over-the-counter drugs
   Ambulance services
   Pre-natal care
   Orthodontia
   Vision care
   Contact lenses
   Seeing eye dogs
   Tape Recorders for blind persons
   X-ray treatments
   Nursing services
   Dental services
   Insulin
   Chiropractic and osteopathic services
   Chemical dependency services
   Psychiatric care
   Prescription eyeglasses
   Hearing aids
   Wheelchairs
   Crutches

   As noted earlier, you can be reimbursed only for expenses incurred during your Period of Coverage for that Plan Year. In addition, no health care expense will be reimbursed under this Plan to the extent that either the expense is covered and paid or reimbursed by any health or accident plan or insurance policy covering you, your spouse, or any Dependent, or if you will be reimbursed for the expense from another source.

5. Dependent Care Reimbursement Expenses. You may also set aside available Pre-tax Contributions in a dependent care reimbursement account. This account can be used to reimburse you for amounts paid for household services or for the care of a Qualifying Individual if those amounts are paid to permit you (and your spouse, if married) to be gainfully employed during a period for which there is a Qualifying Individual with respect to you.

If expenses are incurred outside of your household, they will be eligible for reimbursement only if they are incurred for the care of a Qualifying Individual under the age of thirteen (13) or a Qualifying Individual that spends at least eight (8) hours per day in your household. In addition, if the expense is incurred outside your home at a facility that provides care for more than six (6) individuals that do not regularly live in the facility, the facility must comply with all applicable state and local laws and regulations, including any applicable licensing requirements.

For example, if you must place your four year old son in a child care center in order for you to work as a full-time employee of the Employer, or to enable your spouse to seek employment while you remain employed by the Employer, this child care expense would be eligible for reimbursement. The cost of schooling for kindergarten or higher is not eligible for reimbursement under the Plan, but the cost of care provided before and after school is eligible.

Subject to Plan limits, you will elect your level of dependent care expense coverage during a Plan Year. The maximum level of coverage is $5,000. A pro rata portion of your annual election will be used to fund your account from time to time. At any point in time during the Plan Year you can claim reimbursement benefits in an amount equal to the remaining balance in your account.

Your account for each Plan Year only covers expenses incurred during your Period of Coverage for that Plan Year. In addition, the Plan will not reimburse you for amounts you pay for services performed by your Dependent or a Dependent of your spouse or by your child, if the child is under the age of nineteen (19). For example, a payment to your fifteen (15) year-old daughter for baby-sitting your son would not be eligible for reimbursement.

For more information about the Dependent Care Reimbursement Account, you may contact your local IRS office for a copy of Publication 503.

ARE THERE ANY SPECIAL RULES RELATING TO REIMBURSEMENT BENEFITS?

1. Forfeitures. Federal tax laws require that your health care expense reimbursement account and dependent care reimbursement account for each Plan Year operate on a "use it or lose it" basis. For this reason, if you do not use the entire amount available for reimbursement benefits from these accounts for a Plan Year, *you will forfeit the unused amount*, and you will have no further claim to it. Forfeited amounts will be used by the Employer to offset administrative costs of the Plan.

   For example, assume Jones allocates $2,400 during 2004 to his 2004 Dependent care reimbursement account. During the 2004 Period of Coverage, however, Jones and his spouse and Dependents incur only $2,200 of expenses eligible for reimbursement under the Plan. Jones will forfeit to the Employer the $200 remaining in his 2004 account after he has been reimbursed for all of his eligible expenses.

2. The Plan Year and the Period of Coverage. You may use your reimbursement accounts for any Plan Year only to pay for reimbursement benefits for that Plan Year.

   Your health care reimbursement coverage and dependent care reimbursement account for a particular Plan Year can only be used to provide reimbursement for eligible expenses incurred during your Period of Coverage for that Plan Year.

For example, if you become a participant on October 1, 2004, and have elected to receive health care reimbursement coverage for your first Plan Year ending December 31, 2004, and you are employed for the full year, you can receive reimbursement only for eligible expenses incurred from October 1, 2004 through December 31, 2004, which is your Period of Coverage for that Plan Year. Expenses incurred in September 2004 or January 2005, are not eligible for reimbursement under your coverage for that Plan Year.

In the case of health care reimbursement coverage, your Period of Coverage will end as of the end of the month of the last paycheck (or, if you are a terminated employee, your last continuation period) for which you pay for coverage.

For example, if Johnson's employment terminates on September 21 and he has paid for health care reimbursement coverage through September and elects not to pay for continuation coverage with after-tax dollars (see Continuation Coverage), his Period of Coverage would end as of the end of October. As a result, he would not be entitled to reimbursement for expenses incurred in November through December of that year. This would be true even if Johnson had elected $1,200 of coverage during the Plan Year and, through October, had paid $900 for the benefit. If Johnson elected to pay for continuation coverage on an after-tax basis, he would extend his Period of Coverage and therefore expenses incurred during this continuation period would be eligible for reimbursement. (These results can differ somewhat if you take a "family or medical leave," your health care reimbursement coverage terminates, and you later reinstate the coverage. See LEAVES OF ABSENCES AND FAMILY OR MEDICAL LEAVES.)

3. When is an Expense "Incurred"? A health care expense or dependent care expense is incurred when the health care or dependent care-giving rise to the expense is provided. The date of billing or payment is irrelevant.

For example, if Jones visits his dentist on December 15, 2003, is billed for the dental services on January 5, 2004, and pays the bill on January 14, 2004, Jones will have incurred the expense on December 15, 2003. Consequently, the expense would be eligible for reimbursement under Jones' health care reimbursement coverage for 2003, but not under his coverage for 2004.

4. How Do I Claim Reimbursement Benefits? If you have elected reimbursement coverage, you may claim reimbursement for eligible health care and/or dependent care expenses until February 15 after the close of the Plan Year. Benefits are paid at least bi-weekly throughout the Plan Year. Your claim must total $50.00 before you can submit your claim for reimbursement. This minimum requirement does not apply to claims filed on or after December 31st for the Plan Year just ended.

To be reimbursed you must follow these simple steps:

- When you enroll, you will receive a *Reimbursement Claim Form* that you will use to submit your first expenses to the Acclaim Benefits Flexible Spending Account Department. Please note: the form allows you to list several expenses on one form, if desired.

- Attach a copy of your bill or receipt or other satisfactory third party documentation of the amount of the expense, the date(s) the expense was incurred (a canceled check is not sufficient) to the *Reimbursement Claim Form*.

- Complete the form in its entirety. Then sign and date the form. (Your signature is certification that each expense is eligible for reimbursement under the Plan, that it has not been previously reimbursed under the Plan, that it is not reimbursable from any other source (e.g., insurance), and that you will not also claim it as a deduction or credit on your income tax return.)

- Fax or Mail the *Reimbursement Claim Form* to the Acclaim Benefits Flexible Spending Account Department. Claims received by Fax or Mail will be audited and entered within 24-hours of initially receiving the reimbursement claim form. It is recommended that you keep a copy of the fax confirmation page for your records.

  Claims should be: faxed to: (763) 278-4004 or (866) 278-4004 (toll free)
  mailed to: PO Box 47338, Minneapolis, MN 55447

- After your claim is reviewed, processed, and approved, a check or advice of deposit will be mailed directly to your home address.

ARE THERE ANY RESTRICTIONS ON RECEIVING BENEFITS?

Tax laws impose a variety of nondiscrimination requirements and benefits tests that must be met before benefits under the Plan will be nontaxable to all employees. These are generally intended to restrict the amount of nontaxable benefits available to certain employees of the Employer who are officers, directors, or "highly compensated". If the Employer believes that any of these requirements or limits may be violated, it may limit the amount of Pre-tax Contributions certain participants may allocate to nontaxable benefits, so that the Plan and its benefits will not be discriminatory.

HOW DO I MAKE A BENEFIT ELECTION?

Prior to the start of your participation in the Plan for a Plan Year, at a time announced by the Employer, you must complete and return to the Employer a benefit election form setting out your benefit elections and indicating how much of your Pre-tax Contributions, if any, that you want used to pay your benefits. If you do not make a benefits election, you will not be able to participate in the Plan for the Plan Year.

If you become a participant after the beginning of a Plan Year, your benefit election will become effective as of the first day of the month and after your benefit election form is filed with the Employer.

HOW DO I CHANGE MY BENEFIT ELECTION?

After a Plan Year begins you generally cannot change your benefit election or allocation of Pre-tax Contributions. You may request a mid-year election change only if you experience a "status change". Any such election change must be on account of and consistent with the status change.

STATUS CHANGES

1. Change in legal marital status (marriage, divorce, death of spouse, legal separation and annulment).
2. Change in the number of tax dependents (birth, placement for adoption, death).
3. Employment status change for you, your spouse or your dependent (termination or commencement of employment, full-time to part-time, unpaid leave of absence, change in worksite, strike or lockout).

4. Dependent satisfies or ceases to satisfy eligibility requirements (attainment of age limit, student status, marriage).
5. Residence change by you, your spouse or dependent; the change must affect eligibility for an underlying benefit, such as moving outside of an HMO service area.
6. Change in coverage due to spouse or dependent's open enrollment.
7. For adoption assistance benefits, if applicable, starting or ending adoption proceedings.

Consistency rule – the requested change must be consistent with the Status Change event. Generally, the Status Change event will result in an eligibility change for you, your spouse or dependent, and your election may increase or decrease depending on the gain or loss of coverage that occurred.

For example, if a participant's spouse becomes unemployed, the participant can stop or reduce the rate of additions to his or her dependent care reimbursement account. However, you may not stop or reduce your health care reimbursement coverage.

Change in Cost or Coverage – Pre-tax Elections

If a cost increase is "significant," you may increase your Pre-tax Contribution election or revoke your Pre-tax Contribution election and make a new election for coverage under a similar welfare benefit plan. If your coverage is "significantly curtailed," you may revoke your election and make a new election for coverage under a similar benefit plan. To meet the "significant curtailment" standard, there must be an "overall reduction in coverage" resulting in reduced coverage to participants in general, not just you, but also your spouse or dependent. If a new option is added or if an option is eliminated, you may make a new election that corresponds to the change.

Change in Cost or Coverage – Dependent Care Reimbursement

Dependent care reimbursement elections can also be changed under the Change in Cost or Coverage rules described above. This means that if your dependent care provider changes its rates, you may modify your dependent care account elections to conform to the change. Also, if you change providers and there is a cost difference with the change, you may change your election. (Note: where the dependent care provider is a family member, some restrictions apply.) Under federal law, health care spending account elections are not eligible for modification under the change in cost or coverage rules.

Medicare or Medicaid Coverage

If you become eligible for Medicare or Medicaid coverage you may be able to reduce or stop your Pre-tax Contribution amounts, if the underlying health care plan allows such a change. If you lose Medicare or Medicaid coverage, you may be able to begin or increase Pre-tax Contribution amounts, again, if the health care plan allows you to begin or increase coverage.

Timing for Election Changes

Any such change in your election must be made using Employer designated forms or systems prior to or after the Status Change, but not later than 30 days after the date of the Status Change. Such a change will generally be effective as of the first day of the month after the Employer receives the form, or, if later, the date the Status Change occurs. Please note that to be effective as of a Status Change, the Employer must receive your form no later than the date of the Status Change.

Automatic Changes

The Employer reserves the right to automatically initiate changes to your elections where a significant change in cost occurs or where the Plan is required to follow a judgment, decree or order that mandates coverage for your dependent.

Rehires

If you terminate employment and are rehired within 30 days of your most recent termination date, your most recent election amounts will be automatically reinstated. If you are rehired more than 30 days after your most recent termination of employment you can make new Pre-tax Contribution elections as a new hire.

WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE OR FAMILY OR MEDICAL LEAVE?

If you take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993, the way in which you may participate in the Plan will depend on whether or not you continue to receive compensation from the Employer. If during a leave you continue to be paid by the Employer, your benefit election will remain in effect and the Employer will continue to withhold Pre-tax Contributions. If you are not being paid by the Employer, your participation in the Plan will be treated in the same way as if you had terminated employment. Thus, you cannot make contributions to your Dependent Care Reimbursement Account, but you can continue to submit claims through the end of the Plan Year or, if earlier, until your account is depleted. Also, you may continue to pay for your health coverage, dental coverage, life coverage and any health care expense reimbursement benefits on an after-tax basis. In doing so, your prior benefit election will be reinstated when you return to work (see Continuation of Coverage section).

If you take a leave of absence that is a family or medical leave under the Family and Medical Leave Act of 1993, you should contact the Plan Administrator in order to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid family or medical leave, you may continue to participate in the Plan provided you continue to pay for your benefits. You can elect to pay for your benefits in one of the following three ways:

1. You can pay for your benefits on a pre-tax basis by allowing us to deduct your required contributions from your paychecks before the leave. (Due to certain tax law restrictions, you can only prepay on a pre-tax basis through the end of a Plan Year.)

2. You can pay for your benefits for the duration of the leave on an after-tax basis by a single lump-sum payment at the beginning of the leave.

3. You can pay for your benefits on an after-tax basis during the leave by sending your payment to City of St Paul on or before the first of each month.

If you receive taxable pay from the Employer during your leave, you can pay for your benefits on a pre-tax basis through Pre-tax Contributions from that pay. If you fail to make arrangements to pay for your benefits during a family or medical leave, the Employer reserves the right to recover the cost of such coverage from you at the end of the family or medical leave to the fullest extent authorized by the Family and Medical Leave Act of 1993.

If you are on a family or medical leave under the Family and Medical Leave Act of 1993 at any point during a Plan Year, you will be entitled to revoke your election with respect to health coverage, dental coverage, life coverage and any health care expense reimbursement benefits under the Plan. Following your return from the family or medical leave you will be entitled to reinstate those coverages for the remainder of the Plan Year, on the terms that applied prior to family or medical leave. However, if you reinstate health care reimbursement coverage following a family or medical leave, (a) your Period of Coverage for the Plan Year will exclude periods for which your coverage had lapsed because of the revocation or termination, (b) no expenses incurred during the excluded period will be eligible for

reimbursement under the Plan, (c) your level of coverage for the Plan Year of the reinstatement will equal your coverage level in effect at the time of your revocation or termination, reduced on a pro rata basis to reflect excluded periods for which your coverage had lapsed, (d) all previously paid benefits will be charged against your revised coverage level, and (e) your revised coverage level can be (i) your coverage level in effect for the Plan Year of the reinstatement reduced on a pro rata basis or (ii) your original coverage level for the period of coverage with higher post-leave salary reductions to make up the difference, if you so elect.

For example, assume that Louise elected $1,200 of health care reimbursement coverage for the Plan Year and was paying for this benefit on a pre-tax basis at a rate of $50 each semi-monthly pay period. On April 1 she began a family/medical leave that extended through May. Through March 31 she had incurred $400 of reimbursable health care expenses. She revoked her election on April 1 and reinstated the coverage on June 1. Because Louise revoked her election rather than continuing it and paying for the coverage using one of the methods described above, any health care expenses she incurred from April 1 through May 31 will not be eligible for reimbursement. Upon reinstatement, her Period of Coverage for the Plan Year will be January through March and June through December of that Plan Year, unless there is an earlier termination under the rules that apply to all participants. Because of this two-month lapse period, upon reinstatement Louise's election for the Plan Year will be adjusted from $1,200 to $1,000 (10/12). Because she has already received $400 of benefits, Louise will be eligible for up to $600 of additional reimbursement for the Plan Year. If Louise elects the higher level ($1,200), her post leave salary reductions will be $128.57 per month and her additional available reimbursement amount for the Plan Year will be $800.

Any revocation, request for reinstatement and post-leave coverage choice must be made using Employer forms. In the case of a revocation, the form must be submitted no later than 30 days after the commencement of the family and medical leave. In the case of a request for reinstatement, the form must be submitted no later than 30 days after return from the family or medical leave.

If you take a military leave of absence you may have a right to have your coverage under the medical expense reimbursement portion of this Plan continued. Upon your return from a military leave of absence you may have a right to reinstate your coverage without any waiting periods.

Please contact the Plan Administrator at 651-266-8880 as soon as you know you will be taking a family or medical leave or a military leave of absence.

HOW ARE QUALIFIED MEDICAL CHILD SUPPORT ORDERS HANDLED?

In certain circumstances, you may be able to enroll a child of a participant in the Plan in the health care expense reimbursement portion of the Plan by filing a "Qualified Medical Child Support Order" (QMCSO) with the Employer. A QMCSO may only be filed with respect to a child of a Participant in the Plan. If you are interested in more information relating to QMCSO and the procedures for filing them with the Plan, please contact the Plan Administrator.

HOW ARE BENEFITS TAXED?

Subject to applicable nondiscrimination requirements discussed above, the Employer believes that contributions used to pay for benefits other than the dependent care benefits will not be subject to federal or Minnesota income taxes or to social security taxes. These contributions and benefit payments will not be reduced by income tax or social security withholding.

Dependent care benefits you receive from your dependent care reimbursement account during a calendar year generally will not be taxable unless they exceed the lower of (a) $5,000 ($2,500 if you are married but file a separate return for the year), reduced by the amount of any dependent care credit you claim for other expenses (see SPECIAL NOTICE CONCERNING DEPENDENT CARE EXPENSES below) or (b) your income limitation for that year. If the amount of dependent care benefits exceeds your income limitation, the excess will be taxable. If you are single, your income limitation for a year is your earned income for that year. If you are married, your income limitation is the lower of (a) your earned income for the year, or (b) your spouse's earned income for the year. If your spouse is a full-time student or is physically or mentally incapable of caring for himself or herself during the year, your spouse will be considered to have earned income of $250 per month if you have one Dependent who qualifies for coverage or $500 per month if you have two or more Dependents who qualify for coverage.

However, to sustain the nontaxable status of dependent care benefits you receive from the Plan, you will be required to report the amount of those reimbursements and the name, address, and social security number or employer identification number of the dependent care provider on your federal income tax return.

By each January 31, as part of your W-2, the Employer will provide you with a statement showing the amount of dependent care reimbursement paid to you during the preceding calendar year so that you can calculate the amount, if any, that was taxable. This statement may be a part of your W-2. The Employer will not withhold income taxes or social security taxes from dependent care benefit payments.

To illustrate the tax savings offered by the Plan, suppose Terry expects to be paid a gross salary of $35,000 during the year. If Terry has two children and expects to have $1000 in health care expenses that will not be covered by insurance or any other health care plan and $2500 in dependent care expenses. Terry may pay these expenses on an after-tax basis from her salary or, by participating in the Plan, she can receive benefits from the Plan which allow her to pay the expenses with pre-tax dollars. The difference is illustrated in the following table. (For illustration purposes it is assumed that Terry pays $1.00 for each $1.00 of health care reimbursement coverage during the Plan Year and she is in the 30% tax bracket.)

Sample Paycheck Comparison	**Without Plan**	**With Plan**
Annual earnings	$35,000.00	$35,000.00
Health care expenses/Dependent care expenses paid through the Plan	-0	-3,500.00
Taxable compensation	**$35,000.**	**$31,500.00**
Estimated Federal Tax Withholding	-10,500.00	-9,450.00
Social Security and Medicare (FICA) Tax (7.65%)	-2,678.00	-2,410.00
After-tax compensation	**$21,822.00**	**$19,640.00**
Health care expenses/Dependent care expenses paid after-tax	-3,500.00	-0
Spendable income after taxes and expenses	**$**	**$19,640.00**

Terry's total gross compensation, considering both gross salary and Plan benefits, will have stayed the same, but her compensation after federal taxes, health care expenses, and dependent care expenses will have increased by $1,318.00.

The full or partial non-taxability of benefits is the primary benefit of the Plan. However, the exact effect the Plan will have on you will depend on the benefits you elect as well as other factors that affect the amount of income taxes you pay.

Note – If you receive nontaxable reimbursement from the Plan for health care or dependent care expenses, you may not deduct or take a credit for these expenses on your tax return.

SPECIAL NOTICE CONCERNING DEPENDENT CARE EXPENSES

Under current law, a tax credit is available for dependent care expenses of the same type eligible for reimbursement through the Plan. The amount of the credit depends on the taxpayer's adjusted gross income and ranges from 20% to 35% of eligible expenses up to a limit of $3,000 of expenses if there is one eligible Dependent and $6,000 of expenses if there are two or more eligible dependents. As indicated above, however, you will not be eligible to take the tax credit for any expenses reimbursed through the Plan. In addition, the maximum amount of expenses eligible for the credit will be reduced on a dollar-for-dollar basis for each dollar of dependent care reimbursements you receive under the Plan.

For example, if you have two children and incur $5,000 of dependent care expenses in 2004, $2,000 of which is reimbursed through the Plan, the maximum amount of your expenses eligible for the credit would be $4,000 ($6,000 less $2,000). Determining whether taking the credit or reimbursement under the Plan is more beneficial involves complex calculations. Because each individual's situation is different, the Employer cannot predict whether or not it would be more beneficial to you to take the tax credit for dependent care expenses or to have your expenses reimbursed under the Plan.

EARNED INCOME CREDIT

Under federal law, an earned income credit is available for individuals with lower incomes. The amount of the credit differs depending on whether or not an individual has children, and is phased out as income increases. Participation in the Plan may affect your eligibility for the earned income credit and/or the amount of the credit. You should consult your tax return instructions and/or your tax advisor to determine whether this credit applies to you and if so, the impact of participating in this Plan.

WHAT EFFECT DOES THE PLAN HAVE ON SOCIAL SECURITY OR OTHER GOVERNMENT BENEFITS?

If you use your Pre-tax Contributions for nontaxable benefits from the Plan, the amount of social security benefits and other government provided, pay-related benefits for which you later may be eligible may be reduced.

For example, if you earn less than the social security wage base, which is $87,900 for 2004 (unlimited for the 1.45% Medicare portion), and you use your Pre-tax Contributions to obtain nontaxable benefits, you will have lower earnings for social security purposes, and retirement and other benefits based on these earnings could also be reduced.

WHAT EFFECT DOES THE PLAN HAVE ON OTHER PAY-RELATED BENEFITS?

Your use of Pre-tax Contributions for nontaxable benefits from the Plan should not affect your benefits from other pay-related benefit plans under other Employer-sponsored plans. All benefits from these pay-related benefit plans, such as Long-Term Disability Insurance, are based on your gross pay without regard to any salary conversion amounts under this Plan. For purposes of Section 457 Deferred Compensation Plans and PERA, compensation is based on gross salary compensation before Pre-tax Contributions under this Plan. Monthly Employer Contributions used to purchase mandatory insurance benefits under the Plan should not be included in the calculations of your compensation.

WHAT HAPPENS IF I TERMINATE EMPLOYMENT?

If your employment terminates, your Pre-tax Contributions will cease. You may be able to elect to continue certain coverages by making after-tax contributions. (See Continuation Coverage.) If you stop making payments toward continuation coverage for the health care reimbursement portion of the Plan, the coverage will cease. (See the discussion of "The Plan Year And The Period Of Coverage" in "Special Rules Relating To Reimbursement Benefits".)

WHAT HAPPENS IF THE PLAN IS AMENDED OR TERMINATED?

The Employer reserves the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended your rights accrued prior to the amendment will not be affected. Your rights for periods after the amendment will depend on the amendment.

If the Plan is terminated, your Pre-tax Contributions to this Plan will cease. If the Plan is terminated, the Employer expects that you would be able to continue receiving reimbursements of eligible dependent care expenses on the same basis as if your employment had terminated.

CONTINUATION OF COVERAGE

WHAT ARE MY RIGHTS TO CONTINUATION COVERAGE?

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is City of St Paul, 240 City Hall; 15 West Kellogg Blvd., St Paul, MN 55102 and 651-266-8880. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days of the date on which coverage is lost after the qualifying event occurs. You must send this notice to the City of St Paul.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

A qualified beneficiary must elect coverage by the date specified on the election form provided by the Plan Administrator upon notification of a qualifying event. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

HOW DOES CONTINUATION COVERAGE FOR MY HEALTH CARE REIMBURSEMENT ACCOUNT WORK?

First, continuation coverage may not be offered if the amount you would be entitled to receive for the remainder of the Plan Year if you elected to continue coverage (your annual election less the amount of any reimbursable claims submitted to The Plan before the date of the qualifying event) would be less than the amount that you would be required to pay in continuation premiums for that coverage for the remainder of the Plan Year.

Second, if continuation coverage is available, you may only be entitled to elect continuation coverage for your health care reimbursement account for the period beginning on the date you would otherwise lose coverage and ending on the last day of the Plan Year in which your qualifying event occurs. Continuation coverage will not be available for the health care reimbursement account for any subsequent Plan Year if:

- The health care reimbursement account is an "excepted benefit" under sections 9831 and 9832 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and
- The maximum amount that the health care reimbursement account can require to be paid for a year of continuation coverage equals or exceeds the maximum benefit available under the account for the Plan Year.

Additional information regarding continuation coverage rights under the health care reimbursement account may be obtained by contacting the Plan Administrator.

If you have questions about your COBRA continuation coverage, you should contact the City of St Paul or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at **www.dol.gov/ebsa**.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

ADMINISTRATIVE INFORMATION

THE PLAN YEAR

The Plan Year begins on January 1 and ends the following December 31.

PLAN ADMINISTRATION

The Plan is a sponsor-administered plan and the Plan Administrator is City of St Paul, whose address, business telephone number, and Employer Identification Number are:

240 City Hall; 15 West Kellogg Blvd.
St Paul, MN 55102
Telephone: 651-266-8880
Employer Identification Number: 41-6005521

The Plan Administrator has contracted with Acclaim Benefits to perform third party administration services for the Plan. Claim forms are available from the Plan Administrator.

The Employer (and persons to whom it has delegated powers, to the extent of such delegations) has total and complete authority to (1) determine conclusively for all parties all questions arising in the administration of the Plan, (2) interpret and construe the terms of the Plan, and (3) determine all questions of eligibility and status of Employees, participants, and beneficiaries under the Plan and their respective interests. Such determinations are binding on all persons, subject to the claims procedures under the Plan.

CLAIMS FOR BENEFITS

Claims under the health insurance, dental insurance, or life insurance are described in the Certificates of Coverage for those benefits. Unless otherwise proved in this document, the Certificates of Coverage or other documents governing a particular benefit plan, the following procedure will apply to claims for benefits under the Plan.

You or your beneficiary may file a written claim with the Employer requesting a benefit under the Plan or objecting to the determination of your benefit.

You must file a claim on the form or forms available for that purpose in order for a claim to be valid. Forms are available from the sources referenced in this booklet, or you may obtain the form you need from the Plan Administrator.

The Plan Administrator will notify you in writing within 30 days after your written application for benefits of your eligibility or non-eligibility for benefits under the Plan. If the Plan Administrator needs additional time to evaluate your claim, it will notify you within the first 30 days how much additional time is needed, but not more than another 15 days. If the Plan Administrator requests additional information, you will have 45 days to provide that information. The review period will be suspended until the specified information is received. If the Plan Administrator determines that you are not eligible for benefits or full benefits, the notice will tell you:

(1) the specific reasons for the denial,

(2) the specific provision of the Plan on which denial is based,

(3) a description of any additional information or material necessary for you to perfect your claim (and an explanation of why such information or material is necessary), and

(4) an explanation of the Plan's claim review procedure, including the time limits applicable to the review procedure and your right to bring a civil action under ERISA following an adverse benefit determination on review.

If the Plan Administrator determines that you are not eligible for benefits, or if you believe that you are entitled to greater or different benefits, you will have the opportunity to have your claim reviewed by the Employee Benefit Committee by filing a petition for review with the Employee Benefit Committee within 180 days after you receive the notice issued by the Plan Administrator. Your petition should state the specific reasons why you believe you are entitled to benefits, or greater or different benefits. You have the right to obtain from the Company, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. You should make sure that your request for review includes all the information relevant to your claim.

Within 60 days after the Employee Benefit Committee receives the petition, Employee Benefit Committee will give you a written decision of its review. The Employee Benefit Committee may hold a hearing for the review of your claim if you request and it decides such a hearing is necessary. The Employee Benefit Committee's written decision will state:

(1) the specific reason or reasons for the adverse determination,

(2) the specific Plan provisions and/or rule on which the benefit determination is based,

(3) that you are entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, and

(4) that you are entitled to bring an action under ERISA.

You may choose to have a representative represent you in the claims procedure. If you do, the Employer may require proof that the individual is authorized to act on your behalf. Note that you must follow this claims procedure if you have a claim, and the failure to do so will prevent you from challenging an adverse decision in court.

WHAT IF I NEED MORE INFORMATION?

This document is just a summary of the actual terms of the Plan. You may examine a copy of the actual Plan from the Plan Administrator at any time during regular working hours. You may also obtain a copy of the Plan by furnishing a written request for a copy to the Plan Administrator, at 240 City Hall; 15 West Kellogg Blvd., St Paul, MN 55102. There may be a charge for the expense of copying the Plan document. Since this document is only considered to be a summary, in case of any inconsistencies between this summary and the Plan, the Plan shall control.

Also, certain information concerning the Plan is filed with the Treasury Department and/or the Department of Labor. Should you wish to correspond with either agency about this Plan, you must refer to Employer Identification Number 41-6005521 and Plan Number 501.

The Plan Administrator has been designated as agent for the purpose of service of legal process. The address of the agent for service of process is the address of the Plan Administrator as shown on the preceding page.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Plan may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information and its improper use. You will receive a separate Notice of Privacy Practices, which will summarize the policies, procedures and safeguards that are taken by the Plan to protect the privacy of your health information and explain your rights under HIPAA's Privacy Rule.

Please keep this information with your Summary Plan Description.

As a Participant in the City of St Paul Cafeteria Plan ("Plan"), you should have received a copy of the Summary Plan Description ("SPD"). Below is a summary of material modification which was recently made to the Plan and which impacts the SPD.

Effective January 1, 2005:

- The Plan will operate using the Final COBRA Regulations issued May 26, 2004.

The Section entitled CONTINUATION OF COVERAGE has been updated to include the following information:

WHAT NOTICE OBLIGATIONS DO I HAVE UNDER COBRA?
The Department of Labor's 2004 final COBRA regulations require plans to establish reasonable procedures for the furnishing of notices that covered employees or qualified beneficiaries are required to provide to the Plan Administrator. The following Procedures apply to the Plan and must be followed by a covered employee or qualified beneficiary providing any of the following COBRA notices: qualifying event notices, second qualifying event notices, disability notices, and change of disability status notices. Failure to follow these Procedures shall reduce or completely eliminate the period of COBRA coverage.

Qualifying Event Notice
COBRA requires that each covered employee or qualified beneficiary is responsible for notifying the Plan Administrator within 60 days after coverage would be lost following the occurrence of the triggering events listed below:

- Divorce or legal separation of a covered employee from his or her spouse;
- Enrollment in Medicare; and
- A dependent child's losing dependent status under the Plan.

The Qualifying Event Notice must indicate the specific triggering event causing the Notice and the date of the triggering event.

Second Qualifying Event Notice
The Plan requires, qualified beneficiaries to provide the Plan Administrator with notice of a second qualifying event occurring after a qualified beneficiary has become entitled to COBRA coverage with a maximum coverage period of 18 or 29 months. Second qualifying events include:

- Death of a covered employee;
- Divorce or legal separation from the covered employee;
- The Covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both);
- A dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

The Second Qualifying Event Notice must indicate the specific qualifying event causing the Notice and the date of the second qualifying event. The Notice must be delivered within 60 days of the occurrence of the second qualifying event, or before the end of the first COBRA continuation period, whichever is earlier.

Disability Notice

A qualified beneficiary who is determined by the Social Security Administration to be disabled must notify the Plan Administrator of the disability determination within 60 days after the date the Social Security makes the determination and before the end of the first 18 months of COBRA coverage. The notice must include a copy of the correspondence received from the Social Security Administration.

Change of Disability Status Notice

A qualified beneficiary with respect to whom a notice of disability determination has been provided to the Plan Administrator must notify the Plan Administrator of a subsequent determination by the Social Security Administration that he or she is no longer disabled. Such Notice must be provided within 30 days after the date of the final determination and must include a copy of the correspondence received from the Social Security Administration.

All Notices Described Above

All the Notices described above must be delivered in writing to City of St Paul at the address listed in this Summary Plan Description for the Plan Administrator. All Notices must be delivered in person, by first class mail, by courier, or by messenger. All Notices may be delivered by the covered employee or qualifying beneficiary, or their representative, if such representative has first hand knowledge of the occurrence of the triggering event. All of the above Notices are required even if the Plan Administrator may have independent knowledge of the occurrence of a triggering event. There is no prescribed form for providing the Notice, so the Notice can be provided in any form that reasonably communicates the information required by these Procedures to be so communicated.

In the event of an unusual or urgent situation, as determined by the Plan Administrator, the Plan Administrator, in its discretion, may accept oral notice of any of the events described herein, in lieu of written notice. Unusual or urgent situations are those situations that may make written notice impractical or that may require an immediate determination of COBRA status in connection with an urgent-care claim.

Please keep this information with your Summary Plan Description.

Below is a summary of material modification which was recently made to the City of Saint Paul Cafeteria Plan ("Plan") and which impacts the Summary Plan Description ("SPD").

Effective January 1, 2005:

- The definition of Dependent for the Plan has been changed due to the Working Families Tax Relief Act of 2004.

  DEPENDENT – A person whom you can claim as a dependent on your federal income tax return. Generally, a person will qualify as your dependent if he/she meets the Internal Revenue Code Section 152 requirements to be either a "qualifying child" or a "qualifying relative."

  Please contact your tax advisor to determine for certain whether any particular individual is a qualified child or a qualified relative under Internal Revenue Code Section 152.